		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038315

Facility Name: HERITAGE MANOR-GIBSON CITY

Address: 525 HAZEL DRIVE (Number) GIBSON CITY (City) 61701 (Zip Code)

County: FORD

Telephone Number: (217) 784-4257 **Fax #** ( )

IDPA ID Number: 370909086002

Date of Initial License for Current Owners: 08/01/80

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[xx]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[xx]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: CRAIG ATER **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) CRAIG L. ATER

(Title) SENIOR V.P. FINANCE

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	75	Skilled (SNF)	75	27,450	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,755	9,736	885	24,376	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	13,755	9,736	885	24,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.80%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1980

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 1980 and days of care provided _____

Medicare Intermediary MUTUAL OF OHMAHA

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	10200	10200	0
IPA	13755	13755	0
medicare	885	885	0
	24840	24840	

IPA BEDHOLDS	0
PP BEDHOLDS	203
PP CONVERS	261

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	147,894	3,857		151,751		151,751	1,822	153,573			1
2	Food Purchase		82,616		82,616		82,616	(425)	82,191			2
3	Housekeeping	54,207	12,819		67,026		67,026	0	67,026			3
4	Laundry	31,148	8,413		39,561		39,561	0	39,561			4
5	Heat and Other Utilities			48,501	48,501		48,501	635	49,136			5
6	Maintenance	43,600	20,441	18,803	82,844		82,844	6,447	89,291			6
7	Other (specify):*							0				7
8	TOTAL General Services	276,849	128,146	67,304	472,299		472,299	8,479	480,778			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800	0	4,800			9
10	Nursing and Medical Records	632,904	45,519	4,097	682,520		682,520	0	682,520			10
10a	Therapy		81,188	50,894	132,082	(181,664)	(49,582)	100,808	51,226			10a
11	Activities	33,919	1,228	0	35,147		35,147	0	35,147			11
12	Social Services	23,111	0	1,181	24,292		24,292	0	24,292			12
13	Nurse Aide Training	8,805	750		9,555		9,555	1,589	11,144			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	698,739	128,685	60,972	888,396	(181,664)	706,732	102,397	809,129			16
	C. General Administration											
17	Administrative	67,896			67,896		67,896	24,539	92,435			17
18	Directors Fees							1,862	1,862			18
19	Professional Services			198,746	198,746		198,746	(193,115)	5,631			19
20	Dues, Fees, Subscriptions & Promotions			53,114	53,114	(41,063)	12,051	(1,987)	10,064			20
21	Clerical & General Office Expenses	76,851	7,317	12,403	96,571		96,571	90,769	187,340			21
22	Employee Benefits & Payroll Taxes			216,120	216,120		216,120	14,315	230,435			22
23	Inservice Training & Education			380	380		380	678	1,058			23
24	Travel and Seminar			5,420	5,420		5,420	(3,421)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			6,148	6,148		6,148	874	7,022			26
27	Other (specify):*			6,798	6,798		6,798	(6,256)	542			27
28	TOTAL General Administration	144,747	7,317	499,129	651,193	(41,063)	610,130	(71,742)	538,388			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,120,335	264,148	627,405	2,011,888	(222,727)	1,789,161	39,134	1,828,295			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,386	73,386		73,386	13,163	86,549			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			90,185	90,185		90,185	(543)	89,642			32
33	Real Estate Taxes			56,185	56,185		56,185	0	56,185			33
34	Rent-Facility & Grounds							5,318	5,318			34
35	Rent-Equipment & Vehicles			2,352	2,352		2,352	10,123	12,475			35
36	Other (specify):*							0				36
37	TOTAL Ownership			222,108	222,108		222,108	28,061	250,169			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					181,664	181,664	0	181,664			39
40	Barber and Beauty Shops	0	0	4,999	4,999		4,999	0	4,999			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					41,063	41,063	0	41,063			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			4,999	4,999	222,727	227,726		227,726			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,120,335	264,148	854,512	2,238,995	0	2,238,995	67,195	2,306,190			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,128)	35		5
6	Rented Facility Space	(50)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,764	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(425)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(768)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,692)	24		19
20	Contributions	(1,035)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,570)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,221)	27		24
25	Fund Raising, Advertising and Promotional	(3,584)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (12,709)		$	30

OHF USE ONLY									
48		49		50		51		52	

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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,904		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 79,904		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 67,195		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **HERITAGE MANOR-GIBSON CITY**

ID# **0038315**

Report Period Beginning: **01/01/00**

Ending: **12/31/00**

Print Other Adjustment

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(425)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	(1,128)	35	Line 5	0
6	Rented Facility Space	(50)	34	Line 6	0
7	Sale of Supplies to Non-Patients	0		Line 7	0
8	Laundry for Non-Patients	0		Line 8	(425)
9	Non-Straightline Depreciation	8,764	30	Line 9	0
10	Interest and Other Investment Income	0	32	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0		Line 10a	0
12	Non-Working Officer's or Owner's Salary	0		Line 11	0
13	Sales Tax	(425)	2	Line 12	0
14	Non-Care Related Interest	0	32	Line 13	0
15	Non-Care Related Owner's Transactions	0		Line 14	0
16	Personal Expenses (Including Transportation)	0	24	Line 15	0
17	Non-Care Related Fees	(768)	20	Line 16	0
18	Fines and Penalties	0		Line 17	0
19	Entertainment	(7,692)	24	Line 18	0
20	Contributions	(1,035)	27	Line 19	(1,570)
21	Owner or Key-Man Insurance	0		Line 20	(4,352)
22	Special Legal Fees & Legal Retainers	(1,570)	19	Line 21	0
23	Malpractice Insurance for Individuals	0		Line 22	0
24	Bad Debt	(5,221)	27	Line 23	0
25	Fund Raising, Advertising and Promotional	(3,584)	20	Line 24	(7,692)
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	(6,256)
29	Non-Paid Workers	0	0	Line 28	(19,870)
30	Donated Goods	0	0	Line 29	(20,295)
31	Amortization Expense	0	0	Line 30	8,764
32				Line 31	0
33				Line 32	0
34				Line 33	0
35				Line 34	(50)
36				Line 35	(1,128)
37				Line 36	0
38				Line 37	7,586
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(12,709)
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	1,822	0	0	0	0	0	0	0	0	1,822	1
2	Food Purchase	(425)	0		0	0	0	0	0	0	0	0	(425)	2
3	Housekeeping	0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	635	0	0	0	0	0	0	0	0	635	5
6	Maintenance	0	0	6,447	0	0	0	0	0	0	0	0	6,447	6
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(425)	0	8,904	0	0	0	0	0	0	0	0	8,479	8
	B. Health Care and Programs													
9	Medical Director	0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	422		0	100,386	0	0	0	0	0	0	100,808	10a
11	Activities	0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,589	0	0	0	0	0	0	0	0	1,589	13
14	Program Transportation	0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	422	1,589	0	100,386	0	0	0	0	0	0	102,397	16
	C. General Administration													
17	Administrative	0	0	24,539	0	0	0	0	0	0	0	0	24,539	17
18	Directors Fees	0	0	1,862	0	0	0	0	0	0	0	0	1,862	18
19	Professional Services	(1,570)	0	5,631	0	(197,176)	0	0	0	0	0	0	(193,115)	19
20	Fees, Subscriptions & Promotions	(4,352)	0	2,365	0	0	0	0	0	0	0	0	(1,987)	20
21	Clerical & General Office Expenses	0	0	90,769	0	0	0	0	0	0	0	0	90,769	21
22	Employee Benefits & Payroll Taxes	0	0	14,315	0	0	0	0	0	0	0	0	14,315	22
23	Inservice Training & Education	0	0	678	0	0	0	0	0	0	0	0	678	23
24	Travel and Seminar	(7,692)	0	4,271	0	0	0	0	0	0	0	0	(3,421)	24
25	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	874	0	0	0	0	0	0	0	0	874	26
27	Other (specify):*	(6,256)	0	0	0	0	0	0	0	0	0	0	(6,256)	27
28	**TOTAL General Administration**	(19,870)	0	145,304	0	(197,176)	0	0	0	0	0	0	(71,742)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,295)	422	155,797	0	(96,790)	0	0	0	0	0	0	39,134	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	8,764	0	0	4,399	0	0	0	0	0	0	0	13,163	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	(543)	0	0	0	0	0	0	0	(543)	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(50)	0	0	5,368	0	0	0	0	0	0	0	5,318	34
35	Rent-Equipment & Vehicles	(1,128)	0	0	11,251	0	0	0	0	0	0	0	10,123	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,586	0	0	20,475	0	0	0	0	0	0	0	28,061	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(12,709)	422	155,797	20,475	(96,790)	0	0	0	0	0	0	67,195	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0030215 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V		$			$	$	1
2	V	10c Adjustment for Related Organization	50,640	GreenTree Therapy	100.00%	51,062	422	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 50,640			$ 51,062	$ * 422	14

Sum_6 422

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6E, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6E, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6E, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 1,822	$ 1,822	15	1822
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				635	635	19	635
20	V	6	Maintenance				6,447	6,447	20	6447
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				1,589	1,589	26	1589
27	V	14	Program Transportation				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				24,539	24,539	29	24539
30	V	18	Directors Fees				1,862	1,862	30	1862
31	V	19	Professional Services				5,631	5,631	31	5631
32	V	20	Fees, Subscription, Promotions				2,365	2,365	32	2365
33	V	21	Clerical & General Office Expenses				90,769	90,769	33	90769
34	V	22	Employee Benefits & Payroll Taxes				14,315	14,315	34	14315
35	V	23	Inservice Training & Education				678	678	35	678
36	V	24	Travel and Seminar				4,271	4,271	36	4271
37	V	25	Other Admin. Staff Transportation				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				874	874	38	874
39	Total			$			$ 155,797	$ * 155,797	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				4,399	4,399	16	4399
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(543)	(543)	18	-543
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				5,368	5,368	20	5368
21	V	35	Rent-Equipment & Vehicles				11,251	11,251	21	11251
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 20,475	$ * 20,475	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	#REF!	$ 197,176	Heritage Enterprises, Inc.		$	$ (197,176)	15	-197176
16	V								16	
17	V	10a	#REF!	73,866	Green Tree Pharmacy	100.00%	174,252	100,386	17	100386
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 271,042			$ 174,252	$ * (96,790)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	0.26	18,610	10	0.20	Directors Fee	$ 620	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Treas	Management	0.10	18,609	10	0.20	Directors Fees	621	line 18, col 7	2
3	Craig Hart	Secretary/Treasurer	Management	0.20	18,609	10	0.20	Directors Fees	621	line 18, col 7	3
4	Bill Froelich	Chairman of Board	Management	0.26	133,064	10	0.20	Salary	4,436	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Treas	Management	0.10	133,063	10	0.20	Salary	4,437	line 17, col 7	5
6	Craig Hart	Secretary/Treasurer	Management	0.20	110,192	10	0.20	Salary	3,675	line 17, col 7	6
7	Joe Warner	President	Management	0.03	103,995	48	0.95	Salary	3,468	line 17, col 7	7
8	Bob Dickson	Executive Vice Presid	Management	0.01	67,757	50	1.00	Salary	2,260	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Presid	Management	0.00	55,818	50	1.00	Salary	1,861	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Presid	Management	0.00	55,536	50	1.00	Salary	1,852	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.00	34,284	40	1.00	Salary	1,143	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.00	42,147	50	1.00	Salary	1,406	line 17, col 7	12
13								TOTAL	$ 26,400		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il 61701
Phone Number: (309) 823-7135
Fax Number: (309) 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,324	23	$ 56,457	$ 56,457	75	$ 1,822	1
2	2	Food Purchase	BEDS	2,324	23	6	0	75	0	2
3	3	Housekeeping	BEDS	2,324	23	0	0	75	0	3
4	4	Laundry	BEDS	2,324	23	0	0	75	0	4
5	5	Heat & Other Utilities	BEDS	2,324	23	19,665	0	75	635	5
6	6	Maintenance	BEDS	2,324	23	199,772	50,885	75	6,447	6
7	7	Other	BEDS	2,324	23	0	0	75	0	7
8	9	Medical Director	BEDS	2,324	23	0	0	75	0	8
9	10	Nursing & Medical Records	BEDS	2,324	23	0	0	75	0	9
10	11	Activities	BEDS	2,324	23	0	0	75	0	10
11	12	Social Service	BEDS	2,324	23	0	0	75	0	11
12	13	Nurse Aide Training	BEDS	2,324	23	49,237	43,081	75	1,589	12
13	14	Program Transportation	BEDS	2,324	23	0	0	75	0	13
14	15	Other	BEDS	2,324	23	0	0	75	0	14
15	17	Administrative	BEDS	2,324	23	760,393	760,393	75	24,539	15
16	18	Directors Fees	BEDS	2,324	23	57,693	0	75	1,862	16
17	19	Professional Services	BEDS	2,324	23	174,483	0	75	5,631	17
18	20	Fees, Subscription, Promotions	BEDS	2,324	23	73,288	0	75	2,365	18
19	21	Clerical & General Office Expense	BEDS	2,324	23	2,812,617	2,533,181	75	90,769	19
20	22	Employee Benefits & Payroll Taxe	BEDS	2,324	23	443,562	0	75	14,315	20
21	23	Inservice Training & Education	BEDS	2,324	23	21,017	0	75	678	21
22	24	Travel and Seminar	BEDS	2,324	23	132,330	0	75	4,271	22
23	25	Other Admin. Staff Transportatio	BEDS	2,324	23	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	BEDS	2,324	23	27,096	0	75	874	24
25	TOTALS					$ 4,827,616	$ 3,443,997		$ 155,797	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,324	23	$ 0	$ 0	75	$ 0	1
2	30	Depreciation	BEDS	2,324	23	136,322	0	75	4,399	2
3	31	Amortization of Pre-Op & Org	BEDS	2,324	23	0	0	75	0	3
4	32	Interest	BEDS	2,324	23	(16,821)	0	75	(543)	4
5	33	Real Estate Taxes	BEDS	2,324	23	0	0	75	0	5
6	34	Rent-Facility & Grounds	BEDS	2,324	23	166,328	0	75	5,368	6
7	35	Rent-Equipment & Vehicles	BEDS	2,324	23	348,617	0	75	11,251	7
8	36	Other	BEDS	2,324	23	0	0	75	0	8
9	38	Medically Nec Transportation	BEDS	2,324	23	0	0	75	0	9
10	39	Ancillary Service Centers	BEDS	2,324	23	0	0	75	0	10
11	40	Barber and Beauty Shops	BEDS	2,324	23	0	0	75	0	11
12	41	Coffee and Gift Shops	BEDS	2,324	23	0	0	75	0	12
13	42	Other	BEDS	2,324	23	0	0	75	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 634,446	$		$ 20,475	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	National City		XX	Mortage	$8,541.00	01/20/94	$ 1,320,049	$ 870,093	01/20/01	0.0725	$ 66,717	1
2	National City Loan Amortization		XX	Mortgage							840	2
3	Central Office Allocation		XX	Interest Income							(543)	3
4												4
5												5
	Working Capital											
6												6
7	National City working Capital										22,662	7
8												8
9	TOTAL Facility Related				$8,541.00		$ 1,320,049	$ 870,093			$ 89,676	9
	B. Non-Facility Related*											
10	Interest Income										(34)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,320,049	$ 870,093			$ 89,642	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	21,322	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	37,809	2
3. Under or (over) accrual (line 2 minus line 1).	$	16,487	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	39,698	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	56,185	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	50,411	8
	1996	53,400	9
	1997	58,759	10
	1998	57,580	11
	1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1979	$ 20,000	1
2	Nursing Home				2
3	TOTALS			$ 20,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71				$ 815,350	$		$	$	$	4
5	4				912,769						5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Improvements			1981	41,753						9
10	1982 Improvements			1982	6,437						10
11	1983 Improvements			1983	240						11
12	1984 Improvements			1984	873						12
13	1985 Improvements			1985	7,530						13
14	1986 Improvements			1986	20,979						14
15	1987 Improvements			1987	2,222						15
16	1988 Improvements			1988	2,452						16
17	1989 Improvements			1989	28,639						17
18	1990 Improvements			1990	99,326						18
19	1991 Improvements			1991	36,637						19
20	1993 Improvements			1993	40,838						20
21	1994 Improvements			1994	66,399						21
22	1995 Improvements			1995	1,060						22
23	WINDOW REPLACEMENTS			1996	25,247						23
24	WATER HEATER			1996	1,639						24
25	RESIDENT ROOM REMODEL/PAINTING			1996	7,584						25
26	Parking Lot			1998	12,299						26
27											27
28	Smoke Dampers			1999	5,256						28
29	Water Heater			1999	1,971						29
30	Garbage Disposal			1999	1,693						30
31	Heat/Cool compressor			1999	3,277						31
32	Smoke Dampers			2000	1,295						32
33											33
34	C/O Allocation							4,399	4,399		34
35	Book Depreciation					56,012		65,473	9,461	1,070,313	35
36	TOTAL (lines 4 thru 35)				$ 2143765	$ 56,012		$ 69,872	$ 13,860	$ 1,070,313	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 270,082	$ 17,374	$ 16,677	$ (697)		$ 202,720	37
38	Current Year Purchases	3,005						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 273,087	$ 17,374	$ 16,677	$ (697)		$ 202,720	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 73,386	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 86,549	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 13,163	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,273,033	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,475 Description: Copier, Cell Phone and Central Office Allocation
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		750		750
3	Classroom Wages (a)		8,805		8,805
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		1,589		1,589
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 11,144	$	$ 11,144
10	SUM OF line 9, col. 1 and 2 (e)	$ 11,144			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$	863	$ 21,997	$	863	$ 21,997	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs		188	8,669		188	8,669	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs		858	20,396	164	858	20,560	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				181,410		181,410	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				254			254	13
14	TOTAL			$	1,909	$ 51,316	$ 181,574	1,909	$ 232,890	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj -2446
st adj 3735
Ot adj -867

drugs 100386

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 631	$	1
2	Cash-Patient Deposits	2,953		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	251,586		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,394		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,410,772		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,680,336	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	1,967,347		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	322,865		16
17	Accumulated Depreciation (book methods)	(773,931)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	0		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,536,281	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,216,617	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 16,738	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,953		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,825		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,359		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,698		32
33	Accrued Interest Payable	7,490		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		(499)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 186,564	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	870,093		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 870,093	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,056,657	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,159,960	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,216,617	$	48

***(See instructions.)**

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,931,806	1
2	Restatements (describe):		2
3	**audit Adjustment**	3,927	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,935,733	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	224,227	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 224,227	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,159,960	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,480,109	1
2	Discounts and Allowances for all Levels	(257,442)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,222,667	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	81,580	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 81,580	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	289	12
13	Barber and Beauty Care	6,155	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50	16
17	Sale of Drugs	152,305	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	0	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 158,799	23
	D. Non-Operating Revenue		
24	Contributions	176	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 176	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,463,222	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 472,299	31
32	Health Care	888,396	32
33	General Administration	651,193	33
	B. Capital Expense		
34	Ownership	222,108	34
	C. Ancillary Expense		
35	Special Cost Centers	4,999	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,238,995	40
41	**Income before Income Taxes (line 30 minus line 40)****	224,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 224,227	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,088	$ 35,189	$ 16.85	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	5,958	6,373	107,601	16.88	3
4	Licensed Practical Nurses	7,400	8,063	110,522	13.71	4
5	Nurse Aides & Orderlies	32,526	34,706	364,765	10.51	5
6	Nurse Aide Trainees	1,017	1,017	8,805	8.66	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,671	1,798	14,827	8.25	8
9	Activity Director					9
10	Activity Assistants	3,420	3,519	33,919	9.64	10
11	Social Service Workers	2,043	2,092	23,111	11.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,454	17,908	147,894	8.26	15
16	Dishwashers					16
17	Maintenance Workers	4,740	5,011	43,600	8.70	17
18	Housekeepers	6,988	7,388	54,207	7.34	18
19	Laundry	4,060	4,377	31,148	7.12	19
20	Administrator	2,080	2,080	67,896	32.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,967	6,516	76,851	11.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,196	102,936	$ 1,120,335 *	$ 10.88	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		4,800		36
37	Medical Records Consultant		1,200		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,118		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,181		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,299		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula Johnson	Administrator	0.00%	$ 67,896
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,896

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 197,176
All Legal is adjusted to zero	Legal	1,570
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 198,746

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,177
Unemployment Compensation Insurance	10,256
FICA Taxes	85,706
Employee Health Insurance	75,108
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	23,873
Employee Benefits - central office	14,315
TOTAL (agree to Schedule V, line 22, col.8)	$ 230,435

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,122
Health Care Worker Background Check	
(Indicate # of checks performed)	280
Central Office Allocation	2,365
Promotional Advertising	1,799
Public Relations	1,785
Dues and Subscriptions	4,595
License and Fees	270
Less: Public Relations Expense	(1,785)
Non-allowable advertising	(768)
Yellow page advertising	(1,799)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,064

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,387
	94
Seminar Expense	3,939
Non Allowable	(7,692)
Central Office Allocation	4,271
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number HERITAGE MANOR-GIBSON CITY # 0038315 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **yes** If YES, have these costs
been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,000** Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **xx** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **41,063**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **no** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **yes** Indicate the amount. $ **2,469**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned for providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **no** If no, please explain. **Not complete as of the filing date.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount	
1009			PETTY CASH	631						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	251586						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1135			ACCOUNTS RECEIVABLE-IC							
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	14394						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY							
1310			SUPPLIES INVENTORY							
1409			LAND	20000						
1450			FURNITURE & EQUIPMENT	322865						
1460			ACCUM DEPR-FURN & EQUIP	-249819						
1475			BUILDING & IMPROVEMENTS	1967347						
1490			ACCUM DEPR-BUILDING	-524112						
1530			RESIDENT FUNDS	2953						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	1410772						
2010			ACCOUNTS PAYABLE	-16738						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-29523						
2110			ACCRUED VACATION PAY	-60302						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-30359	-30359					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		499					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	-7490						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE							
2350			REAL ESTATE TAX PAYABLE	-39698						
2385			ACTIVITY FUND	499						
2390			SECURITY DEPOSITS							
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-2953						
2600			MORTGAGE PAYABLE	-870093						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-1935733						
2970			PROFIT/LOSS FOR PERIOD	-224227						
3007.1			PATIENT DAYS-PRIVATE	10200						
3007.2			PATIENT DAYS-IPA	13755						
3007.3			PATIENT DAYS-MEDICARE	885						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-947294		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	-1157031		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	-198386		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE	-53518		0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVATE	-114676		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	-152305		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-81580		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT INC							
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	257442		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16	RENT INCOME	-50		6	0	6	-50	
3530		13	BEAUTY SHOP	-6155		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	-285		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	-4		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-9204		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0	
3600		21	MISC INCOME	0		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	71138	76851	21	1	17	0	
4111			ADMINISTRATOR WAGES	67896	67896	17	1	0	0	
4115			VACATION & SICK - G&A	5713		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	10201	216120	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0	
4130			EMPLOYEE SCHOLORSHIP WAGE	9881		21	1	0	0	
4135			EMPLOYEE SCHOLORSHIP COST	3791		23	3	0	0	
4220			DIRECTORS FEES			18	3	0	0	
4250	4255		OFFICE SUPPLIES	7225	7317	21	2	0	0	
4260			TELEPHONE	12403	12403	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	380	380	23	3	16	0	
4280			GENERAL TRAVEL	1387	5420	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	94		24	3	19	0	
4285			EDUCATION & SEMINAR	3939		24	3	19	-7692 ***	
4290			HELP WANTED ADVERTISING	3122	53114	20	3	0	0	-41063
4291			PROMOTIONAL ADVERTISING	1799		20	3	25	-1799	
4292			PUBLIC RELATIONS	1785		20	3	25	-1785	
4300			LICENSES & FEES	41533		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	4595		20	3	17	-768	
4320			CONTRIBUTIONS	1035		27	3	20	-1035	
4350			PROFESSIONAL FEES	1570	198746	19	3	22	-1570	
4355			MEDICAL DIRECTOR	4800	4800	9	3	0	0	
4360			UTILIZATION REVIEW			10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	1200		10	3	0	0	
4363			PHARMACIST FEES	2118		10	3	0	0	
4364			SOC SERV/ACT CONSULT	1181	1181	12	3	0	0	
4370			TV RENTAL	1128		35	3	5	-1128	
4380			INCOME TAXES		6798	27	3	26	0	
4383			BACKGROUND CHECKS	280		20	3	26	0	
4400			PAYROLL TAXES	90215		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	5747		22	3	0	0	
4410			GROUP INSURANCE	75108		22	3	0	0	
4420			LIABILITY INSURANCE	6148	6148	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANCE	21177		22	3	0	0	
4450			CENTRAL OFFICE FEES	197176		19	3	34	-197176	
4460			BAD DEBTS	5221		27	3	24	-5221	
4470			LOST ITEMS-RESIDENTS	542		27	3	0		
4490			MISCELLANEOUS			27	3	0	0	
4510			REAL ESTATE TAXES	56185	56185	33	3	0	0	
4600			LEASED EQUIPMENT	1224	2352	35	3	16	0	
5110			MAINTENANCE SALARIES	40423	43600	6	1	0	0	
5120			MAINTENANCE SICK & VAC	3177		6	1	0	0	
5130			ELECTRIC	26582	48501	5	3	0	0	
5131			NATURAL GAS	13423		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	8496		5	3	0	0	
5134			TRASH COLLECTION	2232	18803	6	3	0	0	
5140			PROPERTY PLANT REPLACEMNT	3156	20441	6	2	0	0	
5160			GENERAL REPAIR & MAINT	17285		6	2	0	0	
5165			MAINTENANCE CONTRACTS	16571		6	3	0	0	
5210			DIETARY WAGES	137897	147894	1	1	0	0	
5220			DIETARY SICK & VAC	9997		1	1	0	0	
5240			SALES TAX			2	3	13	-425	
5248			FOOD PURCHASES	85085	82616	2	2	0	0	
5250			SUPPLIES-DISHWASHING	1258	3857	1	2	0	0	
5260			DIETARY REPLACEMENT	90		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	2509		1	2	0	0	
5295			MEAL CREDIT	-2469		2	2	0	0	
5310			LAUNDRY WAGES	28887	31148	4	1	0	0	
5340			LAUNDRY SICK & VAC	2261		4	1	0	0	
5370			LAUNDRY REPLACEMENT	4224	8413	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	4189		4	2	0	0	
5410			HOUSEKEEPING WAGES	51019	54207	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	3188		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	4222	12819	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PPR	8597		3	2	0	0	
6010			RN WAGES-MEDICARE		632904	10	1	0	0	
6020			RN WAGES-NON MEDICARE	98010		10	1	0	0	
6030			DON WAGES	35189		10	1	0	0	
6035			ADON	0		10	1	0	0	
6040			RN SICK & VACATION	9591		10	1	0	0	
6110			LPN WAGES-MEDICARE			10	1	0	0	
6120			LPN WAGES-NON MEDICARE	100068		10	1	0	0	
6130			LPN WAGES OTHER			10	1	0	0	
6140			LPN SICK & VACATION	10454		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	347341		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	17424		10	1	0	0	
6245			CONTRACT NURSES-RN			10	3	0	0	
6246			CONTRACT NURSES-LPN			10	3	0	0	
6247			CONTRACT NURSES-AIDES			10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	8805	8805	13	1	0	0	
6255			NURSE AID TRAINING EXP	750	750	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB			0	0	0	0	
6270			REHAB WAGES	14020		10	1	0	0	
6275			REHAB SICK & VAC	807		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	39083	45519	10	2	0	0	
6295			NURSING SUPPLIES	2881		10	2	0	0	
6390			REPLACEMENT-NURSING	3555		10	2	0	0	
6490			NURSING OTHER	779	4097	10	3	0	0	
7280			DRUG PURCHASES	33303	81188	39	2	0	100386 ***	
7281			DRUG PURCHASES-OTHER	47721		39	2			
7380			LABORATORY SERVICES	254	50894	39	3	0	0	
7410			HOME HEALTH SALARY			39	1	0	0	
7440			HOME HEALTH SICK & VAC			39	1	0	0	
7450			HOME HEALTH EXPENSES			39	3	0	0	
7510			ACTIVITES WAGES	31429	33919	11	1	0	0	
7540			ACTIVITIES SICK & VAC	2490		11	1	0	0	
7590			ACTIVITIES SUPPLIES	1228	1228	11	2	0	0	
7595			ACTIVITIES FEES		0	11	3	0	0	
7610			PT WAGES			39	1	0	0	
7611			PT SICK & VACATION			39	1	0	0	
7620			PT FEES	22842		39	3	0	-2446 ***	
7660			PT SUPPLIES	164		39	2	0	0	
7710			SOCIAL SERVICE WAGES	23111	23111	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	0		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES		0	12	2	0	0	
7740			OT FEE	22864		39	3	0	-867 ***	
7750			SOCIAL THERAPIST FEE		0	12	3	0	0	
7770			SPEECH THERAPY FEE	4934		39	3	0	3735 ***	
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	4999	4999	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910			VOLUNTEER COORDINATOR			21	1	0	0	
7940			VOL COORD SICK & VAC			21	1	0	0	
7960			VOL COORD SUPPLIES	92		21	2	0	0	
8100			RENT		0	34	3	0	0	
8120			INTEREST EXPENSE	89379	90185	32	3	14	0	
8130			DEPRECIATION	73386	73386	30	3	9	8764	
8150			LOAN FEE AMORTIZATION	840		32	3	0	0	41063
9510			INTEREST INCOME	-34		32	0	10	0	
9520			MISC NON-OPERATING INCOME	-176		0	0	0	0	
9700			INCOME TAXES			0	0	0	0	
				2238819	2238995					
					176					
GRAND TOTALS				-224227					-109077	
				(NET INCOME)						
				0						
			FACILITY NAME:							
			FACILITY ID:	0						
			FACILITY UNITS:	89						
			BALANCE SHEET TOTAL	0						
				224227						

1009	1009 PETTY CAS	631	
1100	1100 ACCTS REC	51,012	
1101	1101 ALLOWAN	(5,000)	
1105			
1110	1110 ACCTS REC	42,304	
1125	1125 ACCTS REC	154,339	
1130			
1135	1135 ACCTS REC	8,931	
1140	1140 UNAPPLIEI	0	
1145	1145 A/R SUSPEI	0	
1200	1200 PREPAID IN	0	
1220	1220 OTHER PRI	2,240	
1300	1300 DIETARY II	3,000	
1310	1310 SUPPLIES I	2,715	
1320	1320 LINEN INV	6,439	
1409	1409 LAND	20,000	
1450	1450 FURNITUR	322,865	
1460	1460 #NAME?	(249,819)	
1475	1475 #NAME?	1,967,347	
1490	1475 WINDOW R	(524,112)	
1530	1530 RESIDENT	2,953	
1550	1550 LOAN FEES	0	
1551	1551 LOAN FEES	0	
1575	1575 CLOSED	0	
1850	1850 INTERCOM	1,410,772	
2010	2010 ACCOUNTS	(16,738)	
2095	2095 BONUSES I	0	
2100	2100 ACCRUED	0	
2100	2100 PR CLEARI	(1,592)	
2100	2100 PR CLEARI	(25,583)	
2100	2100 PR CLEARI	(2,348)	
2110	2110 ACCRUED	(60,302)	
2120	2120 U.C. TAXES	(1,013)	
2125	2125 FICA TAXE	(6,245)	
2130	2130 FEDERAL V	(3,942)	
2140	2140 STATE W/H	(1,125)	
2145			
2152	2152 WORKERS	(17,488)	
2225	2225 EMPLOYEE	0	
2230	2230 PAYROLL S	0	
2235	2235 IRA ACCOU	0	
2240			
2246	2246 GROUP INS	0	
2250	2250 401K	(323)	
2260	2260 WAGE GAR	(223)	
2300	2300 ACCRUED	(7,490)	
2320	2320 IPA PAYME	0	
2350	2350 REAL ESTA	(39,698)	
2385	2390 SECURITY	499	
2391	2393 HEART FU	0	
2393	2395 DEFERRED	0	
2395			
2400	2400 CURRENT I	(29,377)	
2512	2512 DUE TO RE	(2,953)	
2600	2600 LASALLE E	(870,093)	
2600	2600 LOAN ADD	0	
2625			
2625			
2695	2695 CURRENT I	29,377	
2720	2720 RETAINED	(1,935,733)	
	2720 RETAINED	(224,227)	
		0	
3007	3007 PATIENT D	10,200	
3007	3007 PATIENT D	13,755	
3007	3007 PATIENT D	885	
3007	3007 PATIENT DAYS-CONVERSION		
3007	3007 PATIENT DAYS-LICENSED		
3007	3007 PATIENT DAYS-TOTAL		
3007	3007 PATIENT DAYS-CONTRA ACCOUNT		
3010	3010 BASIC CHA	(947,294)	
3015	3015 ASSESSME	0	
3020	3020 BASIC CHA	(1,157,031)	
3030	3030 BASIC CHA	(198,386)	
3035	3035 DAY CARE	(1,656)	
3040	3040 LIGHT NUF	(13,548)	
3050	3050 MEDIUM N	(22,602)	
3060	3060 HEAVY NU	(15,493)	
3061	3061 SKILLED N	(1,875)	
3080	3080 NURSING S	(18,658)	
3081	3081 NURSING S	(52,808)	
3082	3082 NURSING S	(22,501)	
3083	3083 NURSING S	(20,709)	
3100	3100 DRUGS-ME	(56,359)	
3101	3101 DRUGS-OT	(95,946)	
3110	3110 PHYSICAL	0	
3111	3111 PHYSICAL	0	
3112	3112 PHYSICAL	(30,923)	
3113	3113 PHYSICAL	(6,008)	
3130	3130 PUBLIC AII	0	
3140	3140 LABORATO	(2,072)	
3150	3150 ST/OT THE	(352)	
3151	3151 ST/OT THE	(240)	
3152	3152 ST/OT THE	(35,500)	
3153	3153 ST/OT THE	(6,386)	
3160	3160 X-RAY SER	-99	
3410	3410 IPA/OTHER	110,141	
3411	3411 MEDICARE	4,934	
3415	3415 PRIOR PER	0	
3420	3420 MEDICARE	142,367	
3440	3440 IPA ASSESS	0	
3450	3450 MEDICARE	0	
3460	3460 Y/E A/R AD	0	
3500	3500 LABOR INC	0	
3520	3525 CONTRIBU	(50)	
3530	3530 BEAUTY SI	(6,155)	
3560	3560 ACTIVITY I	(285)	
3570	3570 VENDING I	-254	
3580	3580 PERSONAL	250	
3590	3590 EQUIPMEN	(9,204)	
3595	3595 RESIDENT	0	
3600	3600 MISC INCO	0	-2464702
4110	4110 G&A WAGI	71,138	
4111	4111 ADMINISTI	67,896	
4115	4115 G&A PTO &	5,713	
4120	4120 EMPLOYEE	8,861	
4125	4125 EMPLOYEE	0	
4130	4130 EMPLOYEE	9881	
4135	4135 EMPLOYEE	3,791	
4245			
4250	4250 OFFICE SU	4,165	
4255	4255 POSTAGE	2,040	
4260	4260 TELEPHON	12,403	
4275	4275 TRAINING	380	
4276	4276 INJURY PR	616	
4280	4280 GENERAL	1,387	
4281	4281 MEAL EXP	94	
4285	4285 EDUCATIO	3,834	
4289	4289 MEETINGS	105	
4290	4290 HELP WAN	3,122	
4291	4291 PROMOTIO	1,799	
4292	4292 PUBLIC RE	1,785	
4300	4300 LICENSE &	41,533	
4310	4310 DUES & SU	4,595	
4320	4320 CONTRIBU	1,035	
4350	4350 PROFESSIO	1,570	
4355	4355 MEDICAL I	4,800	
4360	4360 UTILIZATI	0	
4361	4361 OTHER PH	0	
4362	4362 MEDICAL I	1,200	
4363	4363 PHARMACI	2,118	
4364	4364 SOCIAL SE	1,181	
4370	4370 TV RENTAI	1,128	
4383	4383 BACKGROU	280	
4390	4390 OTHER TA	25	
4400	4400 PAYROLL	90,215	
4401	4401 PAYROLL	5,747	
4410	4410 GROUP INS	75,108	
4420	4420 LIABILITY	6,148	
4430	4430 WORKMAN	19,218	
4435	4435 W/C-FIRST	1,110	
4436	4436 DRUG TES	233	
4440			
4450	4450 CENTRAL (	197,176	
4460	4460 BAD DEBT	2,703	
4461	4461 BAD DEBT	2,518	
4470	4470 LOST ITEM	542	
4475	4475 UNIFORM I	1,340	
4486	4486 SERVICE C	6,010	
4490	4490 MISC EXPE	(762)	
4496	4496 MISC. M.I.S	1,020	666801
4510	4510 REAL ESTA	56,185	
4600	4600 LEASED EQ	1,224	
5110	5110 MAINTENA	40,423	
5120	5120 MAINTENA	3,177	
5130	5130 ELECTRIC	26,582	
5131	5131 NATURAL	13,423	
5133	5133 WATER & S	8,496	
5134	5134 TRASH CO	2,232	
5140	5140 PROP/PLAN	3,156	
5160	5160 GENERAL I	17,285	
5165	5165 MAINTENA	10,561	
5166	5166 MAINT.CO	0	
5210	5210 DIETARY W	137,897	
5220	5220 DIETARY P	9,997	
5240	5240 CLOSED AC	0	
5245			
5248	5248 FOOD PUR	85,847	
5250	5250 SUPPLIES I	1,258	
5260	5260 REPLACEM	90	
5270	5270 KITCHEN S	2,509	
5295	5295 MEAL INC	(2,469)	
5310	5310 LAUNDRY	28,887	
5340	5340 LAUNDRY	2,261	
5370	5370 REPLACEM	4,224	
5380	5380 OUTSIDE L	0	
5390	5390 SUPPLIES	4,189	
5410	5410 HOUSEKEE	51,019	
5440	5440 HOUSEKEE	3,188	
5480	5480 SUPPLIES-(	4,222	
5490	5490 SUPPLIES-I	8,597	
6010			
6020	6020 RN WAGES	98,010	
6030	6030 DON WAGI	35,189	
6035	6035 ADON WA(	0	
6040	6040 RN PTO & I	9,591	
6110			
6120	6120 LPN WAGE	100,068	
6130	6130 LPN WAGE	0	
6140	6140 LPN PTO &	10,454	
6210			
6220	6220 AIDES WA(	347,341	
6230	6230 WARD CLE	0	
6240	6240 AIDES PTO	17,424	
6245	6245 CONTRACT	0	
6246	6246 CONTRACT	0	
6247	6247 CONTRACT	0	
6250	6250 NURSE AII	8805	
6255	6255 NURSE AII	750	
6260	6260 NURSE AII	0	
6270	6270 REHAB WA	14,020	
6275	6275 REHAB PT(	807	
6280	6280 NURSING I	0	
6290	6290 NURSING S	39,083	
6295	6295 NURSING S	2,881	
6390	6390 REPLACEM	3,555	
6490	6490 OTHER	779	
7280	7280 DRUG PUR	33,303	
7281	7281 DRUG PUR	47,721	
7380	7380 LABORATO	254	
7391			
7393			
7510	7510 ACTIVITIE	31,429	
7540	7540 ACTIVITIE	2,490	
7590	7590 ACTIVITIE	1,228	
7595	7595 ACTIVITIE	0	
7610	7610 PHYSICAL	0	
7611	7611 PHYSICAL	0	
7620	7620 PHYSICAL	22,842	
7660	7660 P.T. SUPPL	164	
7710	7710 SOCIAL SE	23,111	
7720	7720 SOCIAL SE	1477	
7730	7730 SOCIAL SE	0	
7740	7740 OCCUPATI	22,864	
7750	7750 SOCIAL TH	0	
7770	7770 SPEECH TH	4,934	
7820	7820 BEAUTICIA	4,999	
7890	7890 BEAUTY SI	0	
7910	7910 VOLUNTEE	0	
7940			
7960	7960 VOLUNTEE	92	
8120	8120 INTEREST	66,717	
8125	8125 ALLOCATE	22,662	
8130	8130 DEPRECIA	73,386	
8150	8150 LOAN FEE	840	
9510	9510 INTEREST	(34)	
9520		0	
9530		(22)	
9700			
		-224227	